

## Oral Health

*Oral health refers to the entire mouth, not just the teeth, and implies optimal function and appearance as well as the absence of active disease. As an integral component of general health, it is a fundamentally enabling condition in healthy, productive lives.*

*Although preventive measures such as the use of fluorides and strategies such as school-based oral health programs have greatly reduced the incidence of dental caries (dental decay) in children, oral diseases still persist among many Maine residents of all ages. Common oral diseases include dental caries, periodontal diseases (gum diseases) and oral cancer. Other oral conditions include malocclusion, congenital defects such as cleft palate, and oral injuries.*

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## Healthy Maine 2000 Goal

### Improve the Oral Health of Maine Citizens

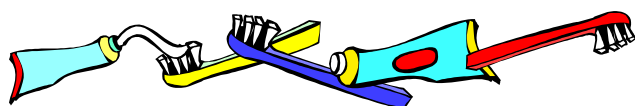
#### Overview

Oral health care for many people in Maine has often been a neglected and fragmented part of general health care. Regular dental visits and oral health screenings are an opportunity for early diagnosis, education, preventive measures and treatment. People who do not receive regular professional dental care may develop chronic oral diseases that can lead to complex treatment, eventual loss of teeth or other oral structures, impaired oral function, speech difficulties and compromised esthetics, as well as compromised overall health status.

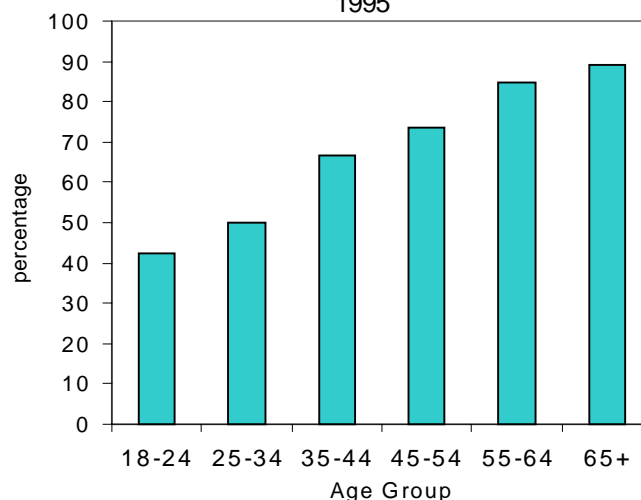
Access to dental services in Maine for low-income individuals, particularly children, has become increasingly problematic during the past decade. The problem of access to dental services is complex, involving not only insurance benefits and reimbursement rates and policies, but also manpower factors, cultural and social issues, Maine's public health infrastructure, and the increased costs of health care.

In 1985, a random sample survey of fifth graders showed that 8 of 10 Maine children had experienced dental decay in either their primary or permanent teeth. This survey has become, to a great extent, the benchmark against which we can measure changes in the oral health of our population, since the children who participated in that survey are now young adults.

Data from the 1990 Behavioral Risk Factor Surveillance Survey indicated that by age 25, 16 percent of Maine's citizens reported having "lost most or all" of their natural teeth; 39 percent of the 45 to 54 year-olds made the same report.



Proportion of Maine People Who Have Lost Any Teeth, by Age Group  
1995



Source: Maine Department of Human Services, Bureau of Health, Behavior Risk Factor Surveillance System

The 1995 Behavioral Risk Factor Surveillance Survey asked a different question: how many teeth the respondent had lost because of tooth decay or gum disease. Data indicated that 2.6 percent of the 25-34 age group and 14.6 percent of those aged 35-44 had lost six or more teeth and 50 percent of the younger group and 66.8 percent of the older group had lost at least one tooth due to preventable causes.

The degree of tooth loss in adults due to tooth decay or gum disease can be a marker of the oral health status of an entire community. A high rate may be an indicator of lack of access to dental care, insufficient exposure to fluorides, or poor oral hygiene and irregular visits to a dentist. Poor oral health in adults may result not only in eventual tooth loss but also in impaired general health, compromised nutrition, days lost from work and inability to obtain or advance in employment. Any tooth loss due to decay or gum disease is considered to compromise oral health status.

### Current Initiatives

The Maine Medicaid Program instituted a substantial dental reimbursement rate increase effective January 1, 1998, along with several other administrative changes in order to improve dental access for Medicaid clients.

Another change is the administration of Maine's Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program, now managed cooperatively by the Bureau of Health and the Bureau of Medical Services. The EPSDT program has the responsibility to assist all Medicaid-eligible individuals under age 21 in finding dental services. Anticipatory guidance for oral health has been integrated into the EPSDT visit schedule, with oral screenings required at ages six months, one, two and three years.

### Shortage of Dental Health Professionals

Low dentist-to-population ratios in rural areas of the state may compound the access problem in those areas. Many low-income families and individuals in rural areas face major problems finding a dentist accepting new patients. However, and just as importantly, regardless of ability to pay, a number of individuals have reported traveling significant distances to obtain needed care, or waiting a long time for routine appointments. Increasingly, long waits are reported anecdotally even in bigger cities and towns. This is especially significant for specialty services such as oral surgery, orthodonture and pediatric dentistry.

Nineteen areas and two state mental health facilities in Maine have been federally designated as Dental Health Professional Shortage Areas/populations; additional areas/populations may be eligible for designation.

Dental Health Professional Shortage Area designations are based on dentist-to-population ratio and low-income population, as well as other characteristics such as fluoridation status and factors related to Maine's rural nature. This federal designation makes those areas eligible for state and federal programs, such as the State Loan Repayment Program (a State and National Health Service Corps [NHSC]

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sponsored program) and the placement of NHSC loan repayment providers; however, appropriate facilities or providers are not always available. Community support systems are usually necessary for these NHSC-supported providers since these health professionals must provide services to all patients regardless of the patients' ability to pay.

What may well be needed are more providers along with more public and private non-profit facilities providing clinical dental care, whether functioning individually or as part of a developed network or system.

In attempts to address this difficult issue, the Bureau of Health's Oral Health Program and the Office of Primary Health Care have provided technical assistance and support to individuals and community groups, as well as to other public and private agencies, by convening workgroups, compiling a resource directory and providing data or other information.

The changes made in 1998 and 1999 in the Maine Medicaid Dental Program should be helpful, along with changes in Cub Care (Maine's Children's Health Insurance Program or CHIP), but may not fully resolve the problems faced by people in rural areas and those who cannot easily afford the dental care they need. Issues related to the supply of dentists and alternatives to the private practice system need further exploration. Broad-based efforts being undertaken by the ad hoc Maine Dental Access Coalition, a coalition of public and private agencies and community groups, as well as local initiatives, are directed at addressing these challenges. Legislative action in the First Regular Session of the 119<sup>th</sup> Legislature should also contribute

### *Issues related to the supply of dentists and alternatives to the private practice system need further exploration*

to long-term solutions, with funds allocated from the tobacco settlement to support community-based oral health and dental services programs, and a dental education loan program to help bring more dentists to the state to practice in underserved areas.

#### **Emerging Initiatives**

The Bureau of Health's Oral Health Program was awarded a grant (beginning in September 1999) from the federal Maternal and Child Health Bureau of the Health Resources and Services Administration. The goal of the funded Maine Oral Health Partnership Project is to develop a broad-based oral health infrastructure by working through and expanding the Maine Dental Access Coalition and by encouraging the development of community coalitions focused on oral health issues and new resources.

For the 1998-99 school year, the Oral Health Program-sponsored School Oral Health Program made 79 grants to schools, school districts and several community agencies to support classroom-based dental health education and fluoride programs for grades K-6 in nearly 250 schools throughout the State.

These programs provided education to approximately 50,000 children (more than 40% of children in those grades), of whom about three-quarters participated in the fluoride mouthrinse component of the program. Participation in the School Oral Health Program has been generally consistent over the past several years.

While fluoride protects the smooth surfaces of teeth, dental sealants prevent decay on the biting surfaces. Beginning with the 1998-99 school year, the Oral Health Program has made funding available to schools participating in the School Oral Health Program to add a dental sealant component to their activities. Nineteen schools in eight funded programs participated in school-based dental sealant programs during the 1998-99 school year. Nearly 450 students in the second and third grades received over 1400 sealants during the school year.

*There is a clear need for data collection on a regular basis in order to assess and monitor the oral health of Maine citizens.*

Funding can be available for up to five years, so that schools can continue to offer sealants and check for retention for children who received sealants through the programs. Plans are to fund more schools for the sealant component each year. This effort will be complemented by activities of the Maine Dental Sealant Project, through a new grant from the Maternal and Child Health Bureau of the Health Resources and Services Administration. The goal of this project is to improve access to preventive and restorative dental services by establishing new community or school based dental sealant programs, with a focus on children who are eligible for Medicaid or Cub Care, or otherwise underserved.

#### **Evaluation**

There is a clear need for data collection on a regular basis in order to assess and monitor the oral health of Maine citizens. A statewide needs assessment has been undertaken, and included primary data collection (dental screenings) with a

*The objectives listed and reported in this chapter include the best numbers available within the limitations of existing data.*

focus on school-aged children conducted during the second half of the 1998-99 school year and in the fall of 1999. A comprehensive report is to be completed late in 2000.

The needs assessment process should result in a coordinated approach to primary and secondary data collection and more reliable information in general about oral health status and needs in Maine. A needs assessment is seen as the initial step in the development of a comprehensive program plan that can provide information to be used to plan appropriate services and systems. The 1999 Oral Health Needs Assessment is the first comprehensive, coordinated effort to assess oral health status and needs in Maine. It has two components: the 1999 Maine State Smile Survey, which assessed the oral health status of a sample of children (primary data); and a review of oral health and related data from a variety of secondary sources. It is expected that the data collected through the 1999 Needs Assessment will impact the direction of future oral health objectives for Maine by providing more accurate baseline information.

Since the Healthy Maine 2000 Oral Health Objectives were set and then adapted in the early through the mid-1990's, some changes were made in the Bureau of Health's focus to accommodate changes in other national reporting standards. In addition, some of the original objectives were not measurable, or highly problematic without regular sources of accurate, reliable data. These objectives were dropped as the decade progressed. The objectives listed

and reported in this chapter include the best numbers available within the limitations of existing data. When screening data is referenced, it should be interpreted to describe only those individuals screened and not extrapolated or projected to describe the state or a population group as a whole.

## *1999 Maine State Smile Survey*

The Bureau of Health's Oral Health Program conducted the 1999 Maine State Smile Survey as part of a statewide needs assessment to help define what types of oral health problems exist for elementary school children in our state, what types of services are currently available, and the extent of unmet needs or underutilized resources. Based on a national model, the 1999 Smile Survey focused on children in kindergarten and third grade. Schools were chosen to participate in the survey based on a random sample of schools stratified by region; for the purposes of the survey, the state was divided into six regions. The sample size was based on ten percent of the number of students in kindergarten and third grade statewide for the 1997/98 school year. Kindergarten was chosen to aid in determining the oral health status of children as they start school. Third grade was chosen to determine the oral health status of school-aged children including the presence of dental sealants. Because the number of children who were actually screened was lower than originally expected, the overall response rate for all schools was only 54 percent; the children screened represent 7.3% of the total enrolled population in the targeted grades. Therefore, results of the 1999 State Smile Survey must be limited to describing the children screened and not the state as a whole. However, it is felt that the

*As with children around the country, approximately 20 percent of the children screened in the Smile Survey had untreated dental decay.*

participating schools were representative of the state and that the findings present a reasonably accurate picture of the oral health status and needs of our school-age children.

Overall, as appears to be the case nationally, many children in Maine have good oral health, but the burden of oral disease - in the case of children's tooth decay - is spread unevenly through the population. In Maine, as in many other places, poor oral health and access to care are associated with low socioeconomic status.

Results of the 1999 Maine State Smile Survey indicate that for both the kindergarten and third grade students screened, those who are eligible for the Free and Reduced Lunch Program (FRL) had significantly poorer oral health. There may have been some regional differences, but the number of children screened was too small to detect regional disparities with confidence. However, the survey clearly indicated disparities by socioeconomic status within and across regions. The kindergarten children screened who were eligible for the FRL Program were 70% more likely to have untreated decay and 60% more likely to have a history of dental decay.

The third graders eligible for the FRL Program were four times more likely to have untreated decay and three times more likely to have a history of dental disease. In terms of access to dental care, all children eligible for the FRL Program were less likely to have visited the dentist in the past year, and their parents reported more difficulty in obtaining dental care.

As with children around the country, approximately 20 percent of the children screened in the Smile Survey had untreated dental decay. Of the kindergarten children who were screened, about one in three had at least one tooth with a history of dental decay, and almost one in five had evidence of untreated decay. Nationally, dental decay affects 52% of eight-year old children. In Maine, 44.7% of the third graders who were screened had a history of dental disease. Almost one-half of the third graders had one or more dental sealants. Over half the third graders and almost one-fifth of the

kindergarten children needed one or more sealants placed. Over three-quarters of the kindergarten children and over 85% of the third graders had been to a dentist within the past year. Eight to ten percent of parents indicated that they had wanted dental care for their children but had not been able to obtain it. The most common reasons given were that they could not afford the care, had no insurance, or that the dentist would not accept Medicaid or their insurance.

## Healthy Maine 2000 Objectives

**Objectives established to improve the oral health of Maine citizens**

### Health Status Objective

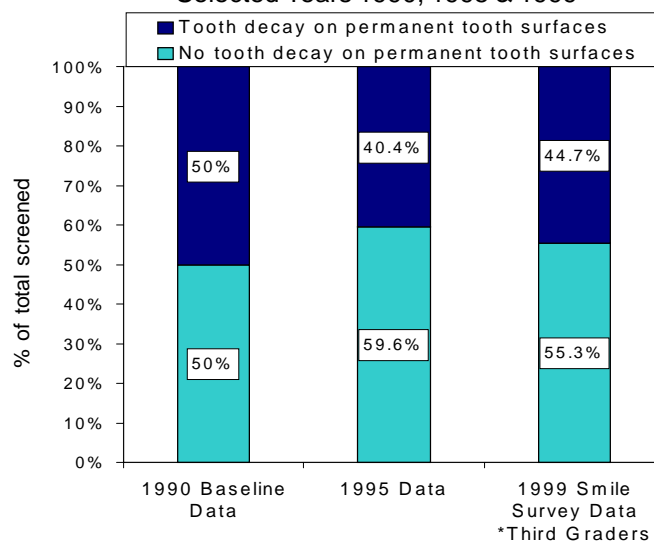
*Increase, to at least 55 percent, the proportion of screened children in the fifth grade who have experienced no decay or fillings on permanent tooth surfaces.*

**Maine 1990 Baseline:** 50% percent of screened fifth grade children had experienced no visible decay or fillings.

**Most Recent Data:** 1995, 59.6% of those screened had no visible decay or fillings (based on results from a small number of individual schools).<sup>2</sup>

Data was collected via the 1999 Smile Survey with a focus on third grade students to align with the national Maternal and Child Health Performance Measures related to dental sealants and screenings which are done at that grade level.

Proportion of Maine Fifth Grade Children Screened Who have Experienced No Decay or Fillings on Permanent Tooth Surfaces Selected Years 1990, 1995 & 1999



Source: Maine Department of Human Services, Division of Community and Family Health, Oral Health Program. Smile Survey 1999 preliminary data

### Risk Reduction Objective

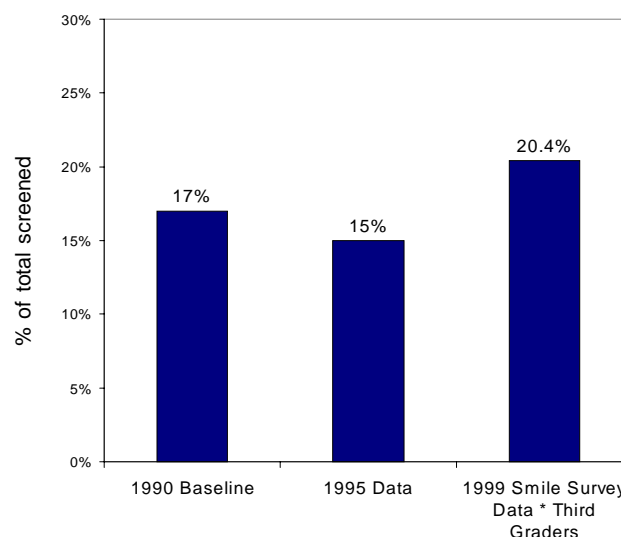
*Reduce to 15% the proportion of screened fifth grade children who had untreated dental caries during a dental screening.*

**Maine 1990 Baseline:** 17% of screened fifth graders had untreated dental caries.<sup>2</sup>

**Most Recent Data:** 1995, 15% of screened fifth graders had untreated caries (based on results from a small number of individual schools).<sup>2</sup>

Data was collected via the 1999 Smile Survey with a focus on third grade students to align with the national Maternal and Child Health Performance Measure related to dental sealants and screenings that are done at that grade level.

Proportion of Maine Fifth Grade Children Screened Who had Untreated Dental Caries During a Dental Screening, 1990 & 1995 1999 Third Grade Data



Source: Maine Department of Human Services, Division of Community and Family Health, Oral Health Program. 1999 Smile Survey Data

The 1999 Smile Survey indicates that 20.4% of the third graders who were screened had untreated dental caries.

## Healthy Maine 2000 Objectives

*Objectives established to improve the oral health of Maine citizens*

### Risk Reduction Objective

*Increase, to 60 percent, the proportion of screened fifth grade children who have received dental sealants on one or more permanent teeth.*

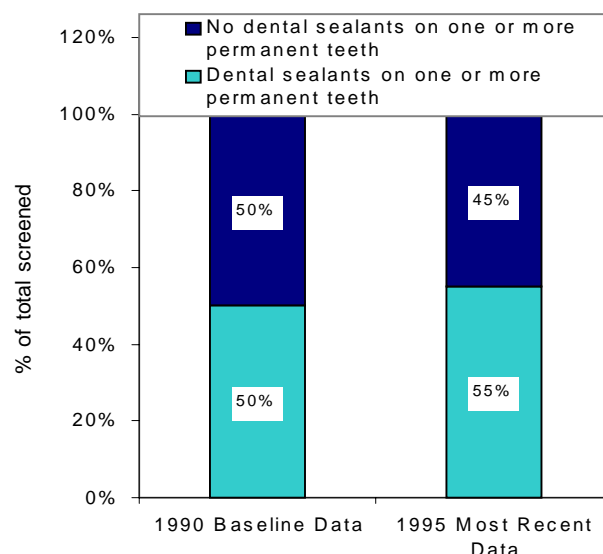
**Maine 1990 Baseline: 50%<sup>2</sup>.**

**Most Recent Data: 1995, 55% of fifth grade children have received dental sealants on one or more permanent teeth (based on results from a small number of individual schools)<sup>2</sup>**

Dental sealants are thin plastic coatings that are painted on the chewing surfaces of molar teeth, an area that naturally may have deep pits and grooves. Ninety percent (90%) of tooth decay in school-age children is found on these surfaces. Sealants seal out the germs that cause decay. Sealants can be applied to molar teeth as soon as they are fully erupted in the mouth; first molars are usually present between ages 6 and 8. For most children, this will be by the time they are in second or third grade. Maine's 1999 State Smile Survey screened third-grade students to align with the related national Maternal and Child Health Performance Measure. Data indicates that almost half of the third-graders (47.6%) screened had at least one dental sealant but that 56.8% of the children screened needed at least one additional sealant placed. When the Healthy Maine 2000 objectives were set, the focus was on fifth-graders for consistency with other national data sets.

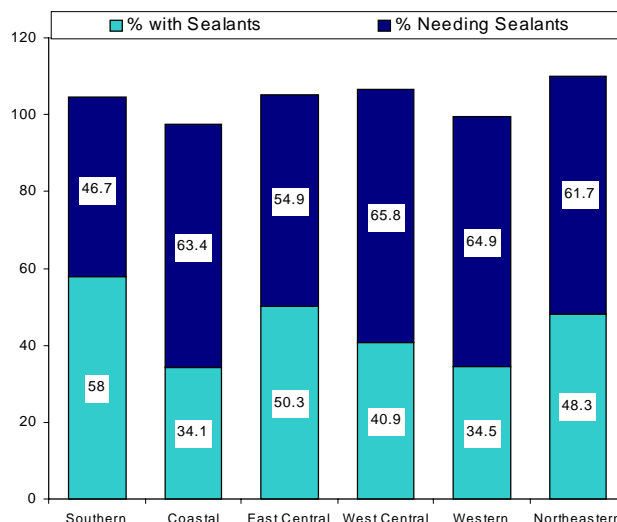
**NOTE:** Data collected during the 1990s and previously reported as the baseline and "most recent" data was collected in a non-standardized manner from a non-representative and voluntary sample. Screenings conducted during those years in different parts of the state show a wide variation and included children in differing grade levels. Sealant prevalence ranged from a high of 62% to 12% or less. The results could not, and should not, be extrapolated to describe the state as a whole and should only be used to describe the particular children screened. The 1999 State Smile Survey reflects a substantial improvement over previous surveys. This 1999 survey data was collected in a standardized manner and the sample was more representative than data from earlier surveys.

Proportion of Maine Fifth Grade Children Screened Who Have Received Dental Sealants On One or More Permanent Teeth 1990 & 1995



Source: Maine Department of Human Services, Division of Community and Family Health, Oral Health Program

1999 Maine Smile Survey  
Proportion of Third Grade Children Screened With or Needing Dental Sealants by Region



Source: Maine 1999 State Smile Survey, Maine Department of Human Services, Bureau of Health, Oral Health Program, publication pending

**Note:** The result above do not add up to 100% as some children had one sealant, but also needed additional sealants.

## Healthy Maine 2000 Objectives

*Objectives established to improve the oral health of Maine citizens*

### Surveillance Objective

*Increase, to 10, the number of elementary schools and agencies that voluntarily report oral health data.*

**Maine 1990 Baseline:** Eight schools participated in dental screenings and reported data.<sup>2</sup>

**Most Recent Data:** 1998-1999 school year, 13 funded school oral health programs participated in dental screenings and reported data from 42 schools.

Schools have been asked to conduct screenings and report oral health status data on a voluntary basis for many years; this activity was reflected in this Healthy Maine 2000 objective. During the 1998-99 school year, 13 funded programs conducted screenings and reported data from 42 schools. However, staff constraints have precluded formal analysis of that data. Beginning with the 1998-99 school year, when the Oral Health program instituted a five-year grant cycle, the requirement was added for programs to conduct screenings that reflect all their participating schools by the end of the second year of funding in each cycle.

### Service and Protection Objective

*Decrease, to 3 percent, the proportion of screened children in the fifth grade who have never visited a dentist.*

**Maine 1994 Baseline:** 5.5%.<sup>2</sup>

**Note:** it is likely that this objective will be changed to focus on children entering kindergarten.

Prevention of oral disease is possible if appropriate measures are applied early enough. Unfortunately, children between ages 2 and 5 are among those who receive the least dental care of any age group, and tooth decay remains the single most common chronic disease of childhood. An early first dental visit allows opportunities for parent and child education, intervention and treatment, if needed. When the Healthy Maine 2000 objectives were set, the focus was on fifth-graders for consistency with other national data sets. However, more recent data has been collected on Maine children entering kindergarten, as well as on kindergarten students through the 1999 State Smile Survey.

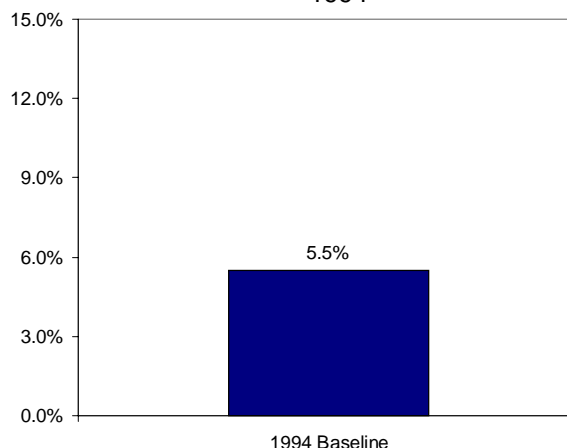
### Bureau of Health's Oral Health Program's School Oral Health Program (SOHP)

Funded Programs by County & Numbers of Schools, 1999-2000 and Participating Students & Number of Students Using Weekly Fluoride Mouthrinse (FM) for 1998-99

County	# of Funded SOHP Programs	# of Participating Schools	# of Participating Students, Gr. K-6 1998-99*	# of Students Using FM, 1998-99*
Androscoggin	3	10	2624	1825
Aroostook	17	36	5918	4629
Cumberland	5	42	12872	10339
Franklin	2	5	693	317
Hancock	5	11	1276	855
Kennebec	8	17	4883	3570
Knox	2	5	1286	888
Lincoln	3	9	1723	1235
Oxford	6	19	4158	2709
Penobscot	11	37	6620	5109
Piscataquis	3	11	1039	871
Sagadahoc	2	2	403	349
Somerset	4	17	3543	2489
Waldo	4	11	1992	1469
Washington	2	13	1197	905
York	2	3	858	745
<b>TOTALS</b>	<b>79</b>	<b>248</b>	<b>51085</b>	<b>38304</b>

\* these figures are reported at the end of the school year based on actual participation and used to determine funding for the following year.

### Proportion of Maine Fifth Grade Children Screened Who Have Never Visited a Dentist 1994



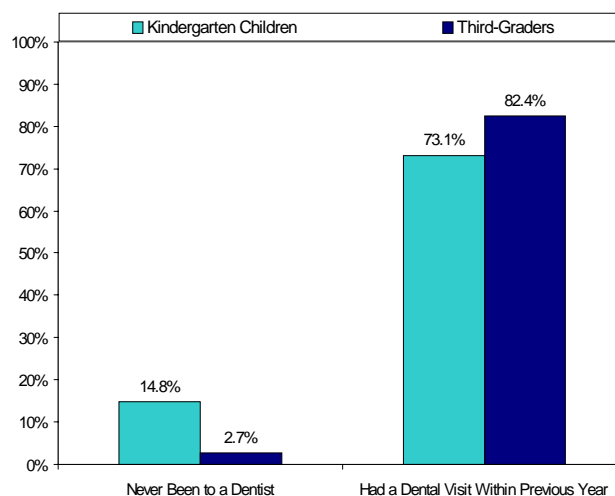
Source: Maine Department of Human Services, Bureau of Health, Oral Health Program, Unpublished Data 1990-1996

## Healthy Maine 2000 Objectives

### Objectives established to improve the oral health of Maine citizens

The 1999 State Smile Survey screened kindergarten and third-grade students. Of the kindergarten children for whom information is available, 14.8% had never been to a dentist, and 73.1% had had a dental visit within the previous year. For the third-graders for whom information is available, only 2.7% had never been to a dentist, 82.4% had had a dental visit within the past year and another 9.6% had been to a dentist between one and three years prior to the parent completing the survey questionnaire. These data indicate that Maine has met the objective of decreasing to 3 percent the proportion of children who have never seen a dentist by the age of eight to ten (when they would be in 5<sup>th</sup> grade). However, the proportion of kindergartners who have reportedly never seen a dentist is still too high.

Proportion of Maine Kindergarten and Third Grade Children Who Have Never Visited a Dentist 1999



Source: Maine 1999 State Smile Survey, Maine Department of Human Services, Bureau of Health, Oral Health Program, publication pending

### Risk Reduction Objective

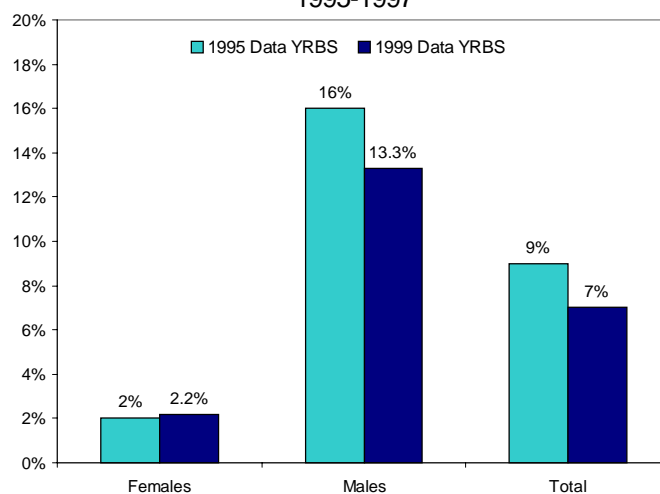
**Reduce, to 8 percent, the proportion of youth who used chewing tobacco or snuff during the past 30 days.**

**Maine 1995 Baseline: 9% Total, 16% males, 2% females in grades 9-12 used smokeless tobacco within the past month.<sup>4</sup>**

**Most Recent Data: 1999, 7% Total, 13.3% males, 2.2% females in grades 9-12 used smokeless tobacco within the past month.<sup>4</sup>**

The use of chewing tobacco or snuff is not a safe alternative to cigarettes. "Spit" tobacco has many of the same risks as do cigarettes because of the concentration of tobacco in the mouth. The use of these products is also linked to tooth abrasion and gum recession, which can be related to an increase in dental decay. Any use of tobacco increases the risks of gum diseases; the use of spit tobacco is clearly linked to cancers of the oral cavity. Tobacco-related oral lesions are common in teenagers who use smokeless tobacco products; such lesions occur in 35% of snuff users and 20% of chewing tobacco users.<sup>7</sup>

Proportion of Maine High School Youth Using Chewing Tobacco or Snuff During the Past 30 Days 1995-1997



Source: Maine Department of Education, Youth Risk Behavior Survey, 1995 & 1999

Note: 1999 data is unweighted.

## Healthy Maine 2000 Objectives

**Objectives established to improve the oral health of Maine citizens**

### Health Status Objective

**Reduce the annual oral cancer mortality rate to 2.5 per 100,000, age-adjusted to the U.S. 1940 population.**

**Maine 1990 Baseline: 2.2 per 100,000**  
**Most Recent Data: 1998, 1.2 per 100,000.**

Oral cancer's risk factors include tobacco use, especially when combined with heavy alcohol use, and exposure to the sun. Oral cancer refers to cancers of the lip, tongue, the palate and the floor of the mouth, the gums and the mucous membranes of the mouth, as well as cancer of the pharynx. Only about half of all persons diagnosed with oral cancer survive more than five years, but early detection through professional examination and timely treatment may be very effective in reducing mortality and morbidity. Maine has a relatively low rate of this disease, and improvements in the rate over the last decade may be attributable to increased awareness by health professionals of the need for screening examinations, as well as some changes in consumer behaviors related to risk factors. However, no specific studies have been conducted to determine what may contribute to the reduction in Maine's oral cancer mortality rate.

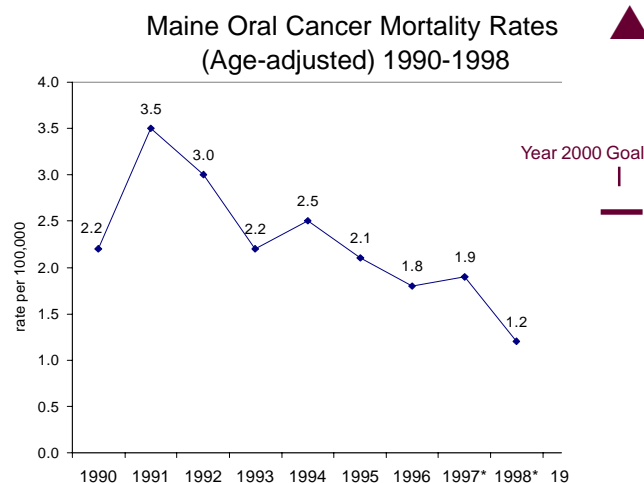
### Risk Reduction Objective

**Increase to 80%, the proportion of Maine people on water supplies who receive fluoridated water, by increasing the number of public water utilities that fluoridate.**

**Maine 1990 Baseline: 50.5% of Maine people on public water supplies received fluoridated water.<sup>5</sup>**

**Most Recent Data: 1999, an estimated 75% of Maine people on public water supplies receive fluoridated water.**

Fluoridation of community water is the single most effective way to prevent tooth decay and improve the oral health of everyone in the community, regardless of age, economic status, or ability to access dental services. Fluoride in the water at the level maintained in drinking water helps to make the surfaces of teeth



Source: Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics

**Note:** Rates were age-adjusted using the U.S. 1940 standard population. \*Data for 1997 & 1998 is preliminary.

resistant to decay. It works by stopping or even reversing the decay process and keeps tooth enamel strong and solid. Water fluoridation is included as one of ten great public health achievements due to its important contribution to the improvement of dental health, general well-being and quality of life for Americans in the second half of the 20<sup>th</sup> Century.

About 75% of Maine people on public water supplies receive fluoridated water. Since only about 47% of Maine people use public water supplies, this means that overall about 35% of Maine's total population has fluoridated water in their homes. There are 65 public water systems supplying fluoridated water to 124 Maine communities.

Maine was the only state in the country to receive the Healthy People 2000 Award presented by the Association of State and Territorial Dental Directors, the Centers for Disease Control and Prevention, and the American Dental Association at an award ceremony in May 2000 during the Annual Meeting of the Association. The Healthy People 2000 Award was given to Maine for being the only state to achieve the national Healthy People 2000 Oral Health Objective to increase to 75 percent the proportion of people served by community water systems providing optimal levels of fluoride. A listing of Maine communities with fluoridated water follows on the next page.

## Healthy Maine 2000 Objectives

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### Maine Communities With Fluoridated Water

Anson	1983	Island Falls
Ashland	1966	Jackman
Auburn	1969	Lewiston
Augusta	1997	Limestone
Baileyville	1955	Lubec
Bangor	1967	Machias
Bar Harbor	1963	Madawaska
Bath	1969	Madison
Belfast	1960	Manchester
Benton	1965	Mars Hill
Bethel	1970	Mechanic Falls
Biddeford	1988	Medway
Blaine	1971	Mexico
Bradley	1963	Milford
Brewer	1967	Millinocket
Bridgton	1963	Monmouth *
Brunswick	1955	Moose River
Bucksport	1969	Newcastle
Camden	1969	Newport
Cape Elizabeth	1997	Northeast Harbor
Caribou	1959	Northport
Chelsea	1997	Norway
Clifton	1967	Oakland
Cumberland	1997	Old Orchard Beach
Cutler Naval Station	1973	Old Town
Damariscotta	1971	Orono
Dexter	1984	Orrington (part)
Dixfield	1971	Owls Head
Dover-Foxcroft	2000	Oxford (part)
Eagle Lake	1974	Perry (part)
East Millinocket	1966	Pittsfield
Eastport	1969	Pittston
Eddington	1967	Pleasant Point
Ellsworth	1969	Portland

\*Community water supplies with natural occurring fluoride

Communities listed by name indicates that all citizens served by the community water supply received fluoridated water (1.2 ppm).

Those communities with "(part)" indicate either that different parts of the community implemented fluoridation at different times, or that not all citizens served by the public water supply receive fluoridated water because the community is served by more than one water supply

### References

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